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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 2/27/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445362	A. BUILDING _____ B. WING _____	01/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF FENTRESS COUNTY	208 DUNCAN ST N JAMESTOWN, TN 38556

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During annual recertification survey conducted on January 11 to 13, 2010, at Signature Healthcare of Fentress County, deficiencies were cited under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000		
F 252 SS=D	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to maintain a clean environment for one (#17) resident of twenty-three residents reviewed. The findings included: Observations of resident #17's room, on January 12, 2010, at 2:50 p.m., revealed the resident's bed had three brown smears, approximately the size of playing cards, upon the quilt covering the bed. The blanket folded on the foot of the bed had two brown smears similar to those on the quilt. Further observations at 4:00 p.m., on January 12, 2010, and again at 8:30 a.m., on January 13, 2010, revealed the soiled blanket and quilt still on the resident's bed. Observations on January 13, 2010, at 11:00 am, revealed the resident's bed had been made, and a clean blanket had been placed over the quilt which was still soiled. Further observations revealed the bottom sheet and draw sheet were also soiled with brown smears. Interview with	F 252	F 252 **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #17 linen was immediately changed to provide a clean, comfortable and homelike environment. **How will you identify other residents potential to be affected by the same deficient practice and what corrective action will be taken.** All residents linen was inspected by Unit Supervisors on 1/13/10 to ensure a safe, clean, comfortable and homelike environment. DON in-serviced licenses staff on duty on 1/13/10 regarding ensuring clean linens for residents. Staff will be in-serviced 2/4/10 by Staff Developer Coordinator on appropriate linen change to provide a safe, clean, comfortable and homelike environment. **What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur.** All residents linen will be audited weekly x 4 weeks, then 50% residents linen will be audited monthly x 2 or until deficient practice is resolved by the DON/ADON. Any identified concerns will be immediately corrected. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.** The DON/ADON will present the resident bed linen audit to the QA committee monthly for review and recommendations.	2/4/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 1/29/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 252	Continued From page 1 nursing supervisor (RN #2), at 11:00 am, on January 13, 2010, in Resident #17's room, confirmed the quilt, draw sheet, and bottom sheet were soiled, and revealed the soiled quilt and sheets should have been replaced when the bed was made.	F 252		
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278	See Next page	

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F 278	Continued From page 2	F 278		

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and interview the facility failed to ensure the information on the resident assessment and the Minimum Data Set were consistent for two residents (#10, #11) of twenty-three residents reviewed.

The findings included:

Medical record review revealed resident #10 was admitted to the facility on May 8, 2009, with diagnoses including Hypertension, Diabetes, Cerebrovascular Accident, and Dementia. Review of the Minimum Data Set dated November 5, 2009, revealed the resident exhibited repetitive physical movements and resisted care. Review of the Monthly Summary completed by nursing dated October 14, 2009, revealed the resident "makes negative statements; repetitive questions; worried facial expression; physically abusive; resists care." Review of the Monthly Assessments dated November 16, 2009, and December 13, 2009, also contained the same information regarding the resident's behavior.

Medical record review revealed resident #11 was admitted to the facility on August 28, 2009, and readmitted on November 16, 2009, with diagnoses including Diabetes, Transient Ischemic Attack, Dementia, Dysphagia, Chronic Obstructive Pulmonary Disease, Coronary Artery Disease, and Pacemaker Insertion. Review of

F278
What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?

Resident # 10 and #11 was audited for MDS accuracy and care plan updated appropriately by MDS coordinator 1/13/10.

How will you identify other residents potential to be affected by the same deficient practice and what corrective action will be taken.

All residents medical records will be assessed to ensure MDS coding and updated as necessary by DON/ADON/MDS by 2/15/10.

Licensed staff in-service provided by Staff Developer and MDS coordinator on assessment accuracy by 2/15/10.

2/15/10

What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur.

MDS personnel will review all documentation in resident medical record with Quarterly review to ensure consistency of documentation.

10% medical record review monthly by DON/ADON to ensure consistency of documentation and MDS coding.

Any concerns identified will be immediately corrected.

How the corrective action (s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.

Concerns will be presented to the QA committee monthly by the DON/ADON,

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F 278	Continued From page 3 the Minimum Data Set dated November 20, 2009, revealed the resident had no behavior issues. Review of the Monthly Assessment completed by nursing dated October 29, 2009, revealed the resident "makes negative statements; repetitive health complaints; repetitive questions; expressing unrealistic fears; repetitive anxious complaints; worried facial expression; repetitive calling out for help." Review of the Monthly Summary dated November 27, 2009, revealed the resident "makes negative statements; self deprecation; repetitive questions; worried facial expression; repetitive calling out for help." During interview on January 13, 2010, at 1:15 p.m., in the Director of Nursing's (DON) office, the DON confirmed that the information on the Minimum Data Set and the Monthly Summary for Residents #10 and #11 was not consistent.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279	See Next Page	

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F 279	Continued From page 4 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to develop a plan of care to meet the resident's needs for one resident (#19) of twenty-three residents reviewed. The findings included: Medical record review revealed resident #19 was admitted to the facility on January 2, 2007, and readmitted on October 19, 2009, with diagnoses including Cerebrovascular Accident with Right Hemiplegia, Hypertension, Seizures, Congestive Heart Failure, Osteoarthritis, Pulmonary Embolism, Rectal Fistula, Gastrostomy Tube, and Dementia. Review of the Resident Care Plan revealed a problem identified on July 17, 2009, with "Communication problem related to speech slurred/mumbled due to past Cerebrovascular Accident, Aphasia. Has difficulty forming words." Review of the interventions for the communication problem included "Keep explanations simple. Ask questions with yes or no answers. Give verbal cues and reminders prn (as needed). Allow for time to communicate; be sensitive to non-verbal communication. May need comments repeated to understand. If unable to understand resident, get another staff to assist." Review of the notes from the Speech Therapist dated July 8, 2009, revealed "Pt. (patient) has severe difficulty expressing needs verbally. Pt.	F 279	F279 **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #19 was reassessed by the Speech therapist and care plan updated according to residents communication needs on 1/14/10. **How will you identify other residents potential to be affected by the same deficient practice and what corrective action will be taken.** All residents triggering for communication on MDS assessment care plan (s) will be audited to ensure care plan reflects resident communication needs. RSM provided in-service to the Therapy staff concerning communicating resident (s) change of status utilizing Therapy to Nursing 24 hour report on 1/14/10. **What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur.** Resident status changes will be reported on the Therapy to Nursing 24 hour report and given to the DON/ADON daily for review during clinical meeting daily to ensure care plan updates. Orders will be obtained and telephone order written for all communication devices. Telephone orders to be reviewed by the DON and MDS coordinator daily and care plan updated as needed. 10% audit will be conducted by DON of residents with communication needs weekly x 4 weeks, and then monthly x 3 to ensure care plans reflect resident needs. Any concerns identified will be immediately corrected. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.** Audit results will be presented to the QA committee quarterly by the DON.	1/14/10

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F 279	Continued From page 5 uses gestures to express most needs with poor success and becomes angry at staff. Staff has been instructed to encourage the pt's use of the communication book at any opportunity they have to communicate with the pt." Continued review of the care plan revealed no mention of the communication book or the resident's anger when gestures are not understood. Review of the care plan revealed no additional interventions to assist with communication with the resident. During interview on January 13, 2010, at 1:30 p.m., in the Director of Nursing's (DON) office, the DON confirmed the staff failed to include the use of the communication book; the resident's anger when gestures were not understood; and additional interventions to communicate with the resident in the resident's plan of care.	F 279		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow the plan of care for two resident (#5 and #12) of twenty-three residents reviewed. The findings included: Medical record review revealed resident #5 was admitted to the facility on January 19, 2006, and	F 282	**F282** **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Head to toe skin assessment completed on Resident # 5 by Wound Care Nurse on 1/13/10 and proper documentation completed. Wound Care Nurse 1:1 with Licensed Nurse on duty to address proper documentation of weekly skin assessment 1/13/10. Resident # 12 side rail was pulled up x 1 by DON to assist the resident in positioning 1/12/10. DON 1:1 with nursing staff on duty to address following resident care plan concerning side rail utilization on 1/12/10.	2/4/10

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F 282	Continued From page 6 readmitted on May 22, 2009, with diagnoses including Closed Head Injury with Persistent Vegetative State and Quadriplegia, Ventriculoperitoneal Shunt; Gastrostomy Tube, Hypertension, Suprapubic Catheter, and Frequent Urinary Tract Infections. Review of the Resident Care Plan dated June 5, 2009, revealed the "resident is at risk for developing a pressure ulcer related to immobility, incontinence, and disease process." Continued review of the care plan revealed one intervention was "Complete Weekly Skin Assessment". Medical record review revealed one Weekly Skin Evaluation dated December 5, 2009, but no weekly skin assessments preceding or following that date. During interview on January 13, 2010, at 1:40 p.m., in the Director of Nursing's (DON) office, the DON confirmed the staff failed to complete Weekly Skin Assessments on this resident as was stated in the care plan. Medical record review for Resident #12 revealed admission to the facility on July 29, 2009 and readmission on September 28, 2009, with diagnoses including Chronic Airway Obstruction, Diabetes Mellitus, Acute and Chronic Renal Failure and Tachycardia. Observation on January 11, 2010, at 2:07 p.m., revealed the resident lying in the bed without side rail in the up position. Observation on January 12, 2010, at 8:12 a.m. thru 8:50 a.m., revealed the resident in bed without a side rail in the up position. Interview with Certified Nurse Aid #1 and Student Practical Nurse #1 on January 12,	F 282	**How will you identify other residents potential to be affected by the same deficient practice and what corrective action will be taken.** 100% resident weekly skin assessment audit were completed by the Wound Care Nurse to ensure proper documentation completed 1/15/10. Care plans updated as necessary. 100% resident care plan were audited by Unit Managers to ensure proper side rail usage in accordance with assessment and care plans on 1/20/10. Staff in-service will be provided on 2/4/10 by Staff Developer/DON concerning importance of weekly skin assessment documentation. Staff in-service will be provided on 2/4/10 by Staff Developer/DON regarding following the resident dare plan and side rail usage. **What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur.** Weekly skin assessment to be audited by the Wound Care Nurse weekly x4, then monthly. Any deficient practice will be immediately corrected and reported to the DON. 10% side rail audit to be completed by the Restorative Nurse monthly to ensure proper following of resident care plan with side rail utilization. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.** Weekly skin assessment audit will be presented to the QA committee quarterly by the Wound Care Nurse. Side rail audits will be presented to the QA committee quarterly by the Restorative Nurse.	2/4/10

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F 282	Continued From page 7 2010, at 8:50 a.m., in the resident's room, confirmed the bed rail was not in the up position. Review of the resident's Care Plan dated October 14, 2009, revealed the resident "requires siderails up x 1 when in bed"..."at all times for positioning". Interview with the Director of Nursing, on January 12, 2010, at 9:05 a.m., in the conference room, confirmed the staff did not follow the care plan of maintaining the side rail in the up position when the resident was in the bed.	F 282		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to promote the dignity of one resident (#18) of twenty-three residents reviewed. The findings included: Medical record review revealed resident #18 was initially admitted to the facility on July 1, 2008, and readmitted on September 23, 2009, with diagnoses including Subdural Hematoma, Hypertension, Breast Cancer, and Urinary Tract Infection with Methicillin Resistant Staphylococcus Aureus. Observation of the resident on January 11, 2010, at 9:34 a.m., revealed the resident lying in bed	F 312	**F312** **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 18 toe nails was immediately addressed with the Podiatrist . **How will you identify other residents potential to be affected by the same deficient practice and what corrective action will be taken.** All resident toe nails were audited by DON/ADON/Unit Managers to ensure nails were clean and trimmed appropriately1/15/10. Nursing staff re-education on 2/4/10 by Staff Developer regarding importance of nail care and reporting to DON and Social Services all residents needing to be seen by the Podiatrist. **What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur.** Licensed staff to audit nails monthly and report to DON and Social Service all resident needing to be seen by the Podiatrist. 10% random audits to be completed by the DON/ADON monthly on resident nails. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.** Audit to be presented monthly to the QA committee by the DON/ADON. Social Service to present a listing of the residents seen by the Podiatrist monthly to the QA committee.	2/4/10

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F 312	Continued From page 8 with the feet uncovered. Observation revealed the toes were edematous and misshapen and the nails of the great toe and the next two toes on each foot were long, very thick, and yellow. Observation of the resident on January 12, 2010, at 2:30 p.m., revealed the resident lying in bed with the feet uncovered and the toenails unchanged. Medical record review failed to reveal a note from a Podiatrist During interview on January 13, 2010, at 1:20 p.m., in the Director of Nursing's (DON) office, the DON confirmed the facility failed to contact the Podiatrist of the condition of the resident's toe nails and the facility had not trimmed the resident's toe nails.	F 312		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329	See next page	2/5/10

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F 329	Continued From page 9 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to discontinue one medication for non-use, for one resident (#6), of twenty-three residents reviewed. The findings included: Resident #6 was admitted to the facility on May 14, 2009, with diagnoses including Acute Myocardial Infarction Chronic Airway Obstruction, Clostridium Deficile, Pain in Limb, Anxiety, Hypertension, and BiPolar. Medical record review revealed a physician's order dated August 25, 2009, "Haldol 2 mg. IM (Intramuscular) q (every) 6 mos. Prn (as needed) agitation." Review of the medication administration records revealed the resident had not received Haldol since the order was given. Interview with Licensed Practical Nurse #1, on January 12, 2009, at 2:45 p.m., in nursing station #1, confirmed the Haldol had not been administered since August 25, 2009. Interview with the Director of Nursing (DON) on January 13, 2009, at 11:30 a.m., in the DON's office, confirmed the order for Haldol was not	F 329	**F329** **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident #6 physician contacted on 1/13/10 and orders obtained to D/C prn medication due to non use. **How will you identify other residents potential to be affected by the same deficient practice and what corrective action will be taken.** All resident physician orders reviewed by DON/ADON/ Unit Managers for prn medications not used >30 days. Physicians contacted and orders obtained to D/C medications due to non use 1/26/10. Licensed nurses in-service on 2/5/10 regarding contacting the Physician for non used medications >30 days by the Staff Developer. **What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur.** 10% chart audit to be completed monthly by DON/ADON for prn medication non use >30days. Residents Physician will be notified of any finding of prn non used medication >30 days. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.** Prn medication audit to be presented to the QA committee quarterly by the DON/ADON.	2/5/10

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	445362	A. BUILDING _____ B. WING _____	01/13/2010

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F 329	Continued From page 10 administered since August 25, 2009. Continued interview with the DON confirmed when the nurses, the Nurse Practitioner, and the Pharmacist reviewed the monthly medications they failed to notify the physician, and the medication was not discontinued. Continued interview with the DON confirmed the facility did not have a policy for non use of medications; however stated the length of time for the non-use of a PRN medication "would be from 30 - 60 days, then the physician would be notified and the medications discontinued."	F 329		
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility dietary department failed to maintain the slicer and floor mixer in a sanitary manner and failed to maintain dish machine wash temperature per the manufacturer's recommended minimum 120 degrees Fahrenheit. The findings included: Observation of the facility dietary department on January 11, 2010, beginning at 10:20 a.m., with the dietary manager present, revealed a floor	F 371	**F371** **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** The floor mixer and slicer were cleaned by the Dietary Manager immediately on 1/11/10. The dishwasher was evaluated by manufacturer representative on 1/12/10 and repaired on 1/20/10 with proper temperatures being maintained. **How will you identify other residents potential to be affected by the same deficient practice and what corrective action will be taken.** Audit of food preparation equipment was performed by Diertary staff to ensure sanitation on 1/12/10. Dietary staff was in-serviced on 1/12/10 by Dietary Manager and Administrator on cleanliness of equipment and water temperature on dishwasher.	1/20/10

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F 371	Continued From page 11 mixer with multi colored dried debris on the underside of the arm. Observation revealed the slicer was covered with a plastic cover which the dietary manager removed to revealed a white greasy ring of debris on the underside of the blade. Interview with the dietary manager, on January 11, 2010, beginning at 10:20 a.m., confirmed the underside of the floor mixer arm had multi colored dried debris. Further interview revealed the plastic covering on the slicer indicated the slicer was clean and ready for use. Continued interview confirmed the underside of the slicer blade had a white greasy ring. Observation of the dish room operation in process on January 11, 2010, at 10:30 a.m., with the dietary manager present, revealed in two consecutive operations the wash temperature was 116 degrees Fahrenheit. Review of the dish machine manufacturer's recommendations revealed the wash temperature minimum of 120 degrees Fahrenheit and the recommended temperature of 140 degrees Fahrenheit. Interview with the dietary manager, on January 11, 2010, at 10:30 a.m., confirmed the actual wash temperature was 116 degrees Fahrenheit in two operations of the machine and the manufacturer's recommendation was a minimum wash temperature of 120 degrees Fahrenheit.	F 371	**What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur.** Dietary staff will record dishwasher temperatures three time daily. Any abnormal temperatures will be immediately reported to Administrator. Dietary Manage will conduct random audits of equipment sanitation 3xweekly for three months then weekly thereafter to ensure equipment is sanitary. Dietary Manager will conduct random audits of dish machine temperature logs three times weekly then weekly thereafter to ensure temperature are within range. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.** Audit results will be presented to the QA committee quarterly for review and recommendations by Dietary Manager.	1/30/10
F 431 SS=D	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug	F 431		

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F 431	Continued From page 12 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation of the medication storage rooms, the facility failed to ensure medications were within the expiration date. The findings included: Observation of the medication storage room on the 300 Hall on January 13, 2010, revealed	F 431	**F431** **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Licensed Nurse removed expired medication from med room 1/13/10. **How will you identify other residents potential to be affected by the same deficient practice and what corrective action will be taken.** All medication rooms/carts audited to ensure no expired medications were present 1/14/10 by Licensed Nurse. Licensed staff in-service concerning responsibility of auditing medications in med room/carts for expired or expiring medications by Staff Developer/Don on 2/5/10. **What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur.** Licensed staff to audit medication rooms/carts weekly for expired/expiring medications. Any expired/expiring medications will be removed and disposed of per policy immediately. Random audit to be completed monthly by the DON/ADON on med rooms/carts for expired/expiring medications. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.** Audit finding will be presented to the QA committee quarterly by the DON/ADON.	2/5/10

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F 431	Continued From page 13 expired medications. Two bottles of MagDelay 64 milligrams expired in November 2009 and were still on the shelf. One bottle of Major Ear Drops expired in December 2009 and was still on the shelf. During interview on January 13, 2010, at 10:30 a.m., in the medication storage room on the 300 Hall, the Licensed Practical Nurse on duty confirmed the three bottles of medication were expired and remained on the shelf.	F 431		
F 443 SS=D	483.65(b)(2) PREVENTING SPREAD OF INFECTION The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. This REQUIREMENT is not met as evidenced by: Based on employee record review and interview, the facility failed to have evidence of one employee (CNA #3) was free of communicable disease of six employee records reviewed. The findings included: Review of the record for Certified Nurse Aid (CNA) #3 revealed a hire date of October 3, 2009. Review revealed no evidence that CNA #3 was free of communicable disease upon hire. Interview on January 13, 2010, at 10:30 a.m., in the conference room, with the Administrator, confirmed the facility had no evidence that CNA #3 was free of communicable disease upon hire.	F 443	**F443** **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** C.N.A. #3 TB skin test was obtained and placed in employee file 1/14/10. **How will you identify other residents potential to be affected by the same deficient practice and what corrective action will be taken.** All employee records to be audited by HR Director to ensure evidence employee is free of communicable disease. By 1/30/10. **What measures will be put in place or what systematic changes you will make to ensure that the deficient practice does not recur.** 10% random monthly audit of employee records for evidence employee is free of communicable disease to be completed by HR Director. List of employee due date and date completed to be presented to the Administrator monthly by HR Director. **How the corrective action (s) will be monitored to ensure the deficient practice will not recur: i.e. what quality assurance program will be put into place.** Random audit results to be presented to the QA committee quarterly by HR Director.	1/30/10